STATE OF NORTH DAKOTA

MARKET CONDUCT EXAMINATION REPORT

NODAK MUTUAL INSURANCE COMPANY

FARGO, ND 58121-0001

As of December 31, 2001

By Representatives of the
North Dakota Insurance Department

May 15, 2003

STATE OF NORTH DAKOTA

DEPARTMENT OF INSURANCE

I, the undersigned, Commissioner of Insurance of the State of North Dakota, do hereby certify that I have compared the annexed copy of the Market Conduct Examination Report of the

Nodak Mutual Insurance Company
1101 First Avenue North
Fargo, ND 58108

as of December 31, 2001, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this _____ day of _____, 2003.

_____
Jim Poolman
Commissioner of Insurance

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APPENDIX A – COMPANY LETTER OF REPRESENTATION

Fargo, North Dakota
April 14, 2003

Honorable Jim Poolman
Commissioner
North Dakota Insurance Department
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Commissioner Poolman:

Pursuant to your authority delegated under the provisions of N.D. Cent. Code Chapter 26.1-03 and in accordance with your instructions, a target market conduct examination of the business practices and affairs has been conducted on:

Nodak Mutual Insurance Company
1101 First Avenue North
Fargo, ND 58108

The examination was conducted at the Company office at 1101 First Avenue North, Fargo, ND 58108. The report on examination is herewith respectfully submitted.

SCOPE OF EXAMINATION

This target market conduct examination commenced on December 6, 2002, and covered the one-year period beginning January 1, 2001 and ending December 31, 2001. It was conducted by representatives from HuffThomas & Company as Examination Consultants for the North Dakota Insurance Department.

This examination was conducted pursuant to the provisions of N.D. Cent. Code Chapter 26.1-03 and in accordance with procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners (NAIC) and/or consistent with the predetermined market conduct program presented to and approved by the North Dakota Insurance Department.

The purpose of this target market conduct examination was to determine the Company's ability to fulfill and the manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders and its compliance with specified sections of N.D. Cent. Code Title 26.1.

This target market conduct examination included a review of the applicable records and files pertaining to the phases listed below.

The Company responded to a series of questions or written inquiries regarding the results of the files being examined.

In order to determine the practices and procedures of the Company's operations, one or more of the

following procedures were performed in each phase:

1. A maximum sample size was calculated for each population of files to be tested using a formula with a 95% confidence level and ± 5% error rate.

2. Random file numbers, equal to the maximum sample size were generated, using Excel software, to select the files for review from each population listing provided by the Company.

3. A portion of each maximum size sample of random numbers generated was selected for initial review.

4. The Company's procedural manuals and/or memoranda were evaluated and each file was then reviewed with the results of testing for various attributes recorded in the examination workpapers.

This examination was comprised of the following five phases:

- Company Operations and Management
- Complaint Handling Practices
- Producer Licensing
- Underwriting Practices
- Claim Handling Practices

A signed letter of representation was obtained during the course of this examination wherein, among other things, the management attested that the transactions and business affairs of the Company are conducted in compliance with the statutes, rules and regulations, and procedures of the State of North Dakota in all material respects. Additionally attesting that they made available in their entirety all books, records, accounts, papers, documents, and computer and other recordings in the Company's possession, relating to its transactions and affairs with regard to its treatment of policy-holders and other appropriate persons, as they pertain to all matters relating to the period under examination. See Appendix A.

This report of examination is confined to comments on exceptions which involve departures from laws, regulations, or bulletins and questionable business practices or patterns which are determined to be contrary or detrimental to the best interests of the insurance buying public and require special explanation or description.

COMPANY OPERATIONS AND MANAGEMENT

History and Profile

Nodak Mutual Insurance Company (hereinafter referred to as "Nodak Mutual" or the "Company") is a mutual property and casualty company founded in 1946 by members of the North Dakota Farm Bureau (hereinafter referred to as the "Farm Bureau"). The Farm Bureau is a voluntary organization of individuals with the collective goal of improving the economic climate of agriculture in North Dakota. During the period under examination, the Company shared a common Board of Directors.

Nodak Mutual is North Dakota's largest domestic property-casualty insurance company. To

become an insured with the Company, applicants must first be a member of the Farm Bureau and, if actively engaged in the business of agriculture, become a full voting member of Farm Bureau. A secondary non-voting class of membership is offered to those not engaged in agriculture and allows them to purchase insurance from Nodak Mutual. The annual dues are the same for each membership class.

The membership as of December 31, 2001, was 12,150 voting members (42%) and 16,546 non-voting members (58%).

Adequacy of Records

Company Operations and Management Standard #1 *- Records are adequately documented to support the decision made.*

The files were evaluated for orderly organization, legibility, structure, and sufficiency of documentation that supported the decisions made. No exceptions were noted.

Company Cooperation

Company Operations and Management Standard #2 *- The Company cooperates on a timely basis with examiners performing the examination.*

The Company cooperated with the examiners and delivered requested records when requested within the timeframe stated by the examiners.

Examiner's Comments

Company Operations

The North Dakota Insurance Department called a target market conduct examination of Nodak Mutual to review concerns that are addressed under the appropriate sections of this examination report.

The period under examination was limited to 2001. The sample selection does not always reflect every issue the Company may have experienced in previous years, and the examiners believe additional comments are needed on some specific issues not included in other sections.

Board Restructuring Proposal

Article III, Section 11 of the proposed changes to the Bylaws requires that anyone who wants to nominate someone for consideration of a Board of Directors that is becoming vacant at the next annual meeting submit this nomination at least 180 days in advance. This time frame seems excessive and should be reconsidered.

No provision has been made for multiple candidates for the same Board seat. A more reasonable approach would be for a person who wanted to run for a Board of Directors opening to become eligible by presenting a petition signed by a specified number of policyholders (for example: 100) which could be submitted to the Board for posting on the ballot sent out to all policyholders. This

would provide for multiple candidates for the open Board seat to be voted on at the next annual meeting. The currently proposed Bylaw is a take it or leave it choice. Even if a policyholder withholds a vote, there is no alternative to vote for someone else and no way to get an alternative on the ballot.

Conflict of Interest

Article 12 of the Articles of Incorporation allows for a Board member to vote on an issue before the Board, even though the Board member has a conflict of interest regarding the issue. For example, a Board member who is also a Farm Bureau Board member or officer would have a conflict of interest in a decision relating to the royalty agreement between Farm Bureau and Nodak Mutual. A Board member should not be involved in the discussion or the decision relating to a matter in which the director has a conflict. Either the Article should be amended to prohibit directors from voting on an issue in which a director has a conflict, or the Board should adopt a policy that, notwithstanding Article 12, a Board member with a conflict of interest on an issue must recuse himself from discussion relating to and from voting on the issue.

Further, the examiners would like to make the following comments and recommendations:

- All Board meetings should be recorded. All actions taken by the Board of Directors on unanimous decisions should be signed by the Board members present, indicating whether the vote was for or against the proposal.

- The Board or a committee appointed by the Board should study the feasibility, necessity, value to the Company, and the amount of any royalty/service fee paid by Nodak Mutual to the Farm Bureau. A study should also be included to justify any recommendations made by the committee. Past payments have been made to the Farm Bureau without regard to the financial condition of the Company and the benefits the Company is obtaining from this arrangement. The percentage amount of the agreement, if any, should be in line with the value to Nodak Mutual and the study should justify this payment.

The Farm Bureau benefits from its association with Nodak Mutual through service fees paid and the availability of a quality insurance product meeting the needs of its members. The Company benefits by having ready access to a membership base to develop and market products that meet the needs of their policyholders who are also Farm Bureau members. The relative value of these benefits should be studied and an arm's length royalty agreement negotiated between Farm Bureau and Nodak Mutual.

COMPLAINT HANDLING PRACTICES

Commissioner Complaints

Commissioner Complaint Handling Standard #1 *- The Company has adequate complaint handling procedures in place.*

The Company does not have a complaint handling procedure manual or any written complaint handling procedures in place. The Company was queried and did provide an explanation of how Commissioner complaints are handled.

The Senior Vice President of Administration receives Commissioner complaints. Complaints are then forwarded to the Legal Department indicating what department the complaint involves. The Legal Department logs the Commissioner complaint on the legal computer system. The file is put on a 10-day tickler and sent to the appropriate individual to answer. An explanation is sent to the Commissioner's office within 10 days and the file is sent for review and closing.

Files were opened within one day of receipt from the Insurance Department.
Recommendation: The Company should adopt written complaint handling procedures.

Commissioner Complaint Handling Standard #2 *- The Company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, regulations, and contract language.*

The Company was requested and did supply all Insurance Department complaints for the examination period.

The Insurance Department complaint register was reconciled with the Company complaint register for the examination period. The Insurance Department complaint register contained 14 complaints. The Company complaint register contained the 14 Insurance Department complaints and 3 complaints not on the Insurance Department register.

File documentation was reviewed to determine if the Company response fully addressed the issues raised. There were no exceptions noted.

In the 17 files reviewed, the Company took adequate steps to finalize the complaint. There were no exceptions noted.

Commissioner Complaint Handling Standard #3 *- The time frame within which the Company responds to complaints is in accordance with established Company guidelines.*

Complaint files were reviewed to determine if the Company responded to the Insurance Department in a timely manner. The Company responded to all Commissioner complaints within 10 working days. No exceptions were noted.

The Company resolved or answered 16 Commissioner complaints within 10 days. The Company resolved one complaint in 15 working days but had requested an extension of time within 10 working days.

Commissioner Complaint Handling Standard #4 *– Records are adequately documented to support the decision made.*

The structure of complaint files was orderly, complete, and legible. Documentation including dates, notations, memoranda, etc. was sufficient to support the decisions made. No exceptions noted.

Commissioner Complaint Handling Standard #5 *- The Company cooperates on a timely basis with examiners performing the examination.*

The Company was cooperative and timely with the production of records during the course of the examination. No exceptions noted.

Internal Complaints

Internal Complaint Handling Standard #1 *- The Company has adequate complaint handling procedures in place.*

The Company does not have a complaint handling procedure manual or any written complaint handling procedures in place. The Company was requested and did provide a written explanation of how internal complaints are handled. The Company handled correspondence primarily expressing a grievance including claims against agent's errors and omissions insurance as a complaint.

Internal complaints are received from consumers via the telephone, mail, or through agents. Complaints are logged into the Legal Department computer system. A complaint file is established to document actions taken on the complaint and maintain all correspondence pertaining to the complaint.

Nodak Mutual's Legal Counsel does the investigative work to determine the facts of the case. Legal Counsel and others who may have insight into the case determine what remedy is appropriate and advise the complainant of the decision.

It appears the Company has a system for tracking and resolving internal complaints; however, they have no written procedures in place. It is recommended the Company adopt and implement written reasonable standards for the prompt handling of written communications primarily expressing a grievance from insureds and claimants, as required by N.D. Cent. Code § 26.1-04-03(10).

Internal Complaint Handling Standard #2 *- The Company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, regulations, and contract language.*

The Company was requested and did supply all internal complaints for the examination period. The complaint register was reviewed to determine all complaints for the examination period were provided.

In the files reviewed, the Company response fully addressed the issues raised and the Company took adequate steps to finalize the complaint. No exceptions were noted.

Internal Complaint Handling Standard #3 *- The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules, and regulations.*

Files were reviewed to determine the number of working days for response time to internal complaints and the results are noted in the table below. The Company has no formal guideline for response time to internal complaints.

Number of Days to Respond	
0-10 working days	6
11-20 working days	2
21-30 working days	1
Total	9

Recommendation: The Company should adopt and implement a standard for timely response to internal complaints.

A time study was performed on internal complaints in working days to determine resolution time. The time was measured from the date the complaint was received until the date it was resolved and the results are noted in the table below. One complaint is not applicable as the Company offered resolution but never received a response from the complainant.

Number of Days to Resolve	
0-15 working days	3
16-30 working days	2
31-45 working days	3
N/A	1
Total	9

Recommendation: The Company should adopt and implement standards and procedures to resolve internal complaints on a timely basis.

Internal Complaint Handling Standard #4 *– Records are adequately documented to support the decision made.*

Complaints were reviewed to determine if the Company was maintaining adequate documentation. Eight of the nine files reviewed were adequately documented.

There was one exception noted when a copy of the customer complaint was not found in the file. According to the Company, the complaint was received by the agent via the telephone who in turn contacted the Company via the telephone. There is no documentation or phone log noting the receipt of the complaint in the file.

According to the Company, the Company's Legal Counsel responded to the complainant in writing. There is no copy of this written response in the file. A complaint was later filed with the Insurance Department.

Upon receipt of a complaint, the Company establishes a file with a number. The file number includes the year it was received. The file contains all pertinent documentation and correspondence. The structure of files was organized and legible. No exceptions were noted.

Internal Complaint Handling Standard #5 *- The Company cooperates on a timely basis with examiners performing the examination.*

Production of records by the Company was timely and no exceptions were noted.

PRODUCER LICENSING

Producer Licensing Standard #1 *- Company records of licensed and appointed (if applicable) producers agree with department of insurance records.*

The Company's producer licensing list was compared and reconciled to the Department's licensed producers list by comparing Social Security numbers, which is also the license number. No exceptions were noted.

During the course of reviewing application files, the written date of the policy was compared to the Department's appointment date to see if policies were written prior to appointment date. No exceptions were noted.

Producer Licensing Standard #2 - The producers are properly licensed and appointed in the jurisdiction where the application was taken.

Nodak Mutual writes in North Dakota only and the agents who work for the Company as independent agents are considered captive agents working only for the Company. Lines of insurance coverage which the Company does not write are submitted to the Nodak Agency, a wholly owned subsidiary of Nodak Mutual, for issuance by other companies.

UNDERWRITING PRACTICES

The scope of this target market conduct examination included only a review of rejections and declinations, cancellations and non-renewals and rescissions; therefore, no review of issued policies was performed.

Rejections and Declinations

Rejection and Declination Standard #1 - *Rejections/declinations procedures are not unfairly discriminatory.*

The Company had a total of 142 rejected applications for the examination period. A sample of 25 files was randomly selected for testing.

The Company accepts all applications and issues policies immediately. Applications are then reviewed and rejected within 10 days if not acceptable.

The sample of rejected applications was reviewed to determine if the Company used valid reasons to reject applications. The Company used valid reasons in 24 rejected applications. There was one exception noted when the Company failed to document the reason for rejection.

Rejection notices to applicants were reviewed to determine if the Company gave specific reasons. The Company included a specific reason in 13 files. In 12 files (48%) the Company failed to include a specific reason for the rejection. Instead, the Company gave a broad and generic response for rejection: "the risk does not meet underwriting criteria" or applications "do not meet our underwriting guidelines."

The Company is in violation of N.D. Cent. Code § 26.1-39-12 which provides "the insurer making the declination shall either provide the insurance applicant with a written explanation of the specific reasons for the declination at the time of declination or advise the applicant that a written explanation of the specific reasons for declination will be provided within twenty-one days of the time of receipt of the applicant's written request for such an explanation."

The Company stated they would conform to N.D. Cent. Code § 26.1-39-12 by advising the applicant that a specific reason will be provided within 10 days of receipt of the applicant's written request for said reason.

One file lacked documentation to determine if Company procedures for rejection were followed and if any discriminatory practices were being used.

It is important to note the Company uses credit reports when underwriting property insurance. The Company rejected eight applicants (32%) in part because of a bad credit report. In two files, the Company did not advise the applicant of the adverse underwriting decision based partially on the use of credit reports.

Recommendation: The Company should advise applicants of the use of credit reports and their right to receive a copy of the credit report when it is used to underwrite insurance.

The Company stated this situation was remedied in October 2001. All letters are now produced by the computer system and advise the applicants of the use of credit reports.

Cancellations and Nonrenewals

Cancellation and Nonrenewal Standard #1 *- Cancellation/nonrenewal and declination notices comply with policy provisions, advance notice requirements and state laws and Company guidelines.*

For the examination, the Company was requested and did provide a copy of its cancellation and nonrenewal procedures. A sample of 25 canceled /nonrenewed policies was randomly selected for testing. No exceptions were noted.

The reason for cancellation is noted in the table below:

Code	Reason	Number
1	Policyholder's Request	11
2	Sold Property	4
3	Nonrenewal by Company	4
4	Non-payment	2
6	Change in policy type	3
8	Moved out of State	1
	Total	25

The Company initiated cancellation in seven (28%) of the files tested. Following are the reasons the Company initiated the cancellations:

1. Cancelled due to high claims experience.

2. Paid policy limits on burned building and canceled policy.

3. Nonrenewal due to underwriting guidelines.

4. Bad credit report.

5. Insured moved out of state.

6. Nonpayment of premium.

One policy was canceled within 10 days of issue because of a bad credit report. Company procedures state the credit report is used similar to a motor vehicle report when underwriting policies. This file appears to be rejection rather than a cancellation because the rejection procedure of issuing and canceling the policy within 10 days was followed.

No specific reason was given to the insureds in the cancellation letter. According to N.D. Cent. Code § 26.1-39-12 "the insurer making the declination shall either provide the insurance applicant with a written explanation of the specific reasons for the declination at the time of declination or advise the applicant that a written explanation of the specific reasons for declination will be provided within twenty-one days of the time of receipt of the applicant's written request for such an explanation."

The Company stated this situation would be corrected by adding the following statement to the letter, "If you would like more specific reasons, please send a written request prior to the effective date of cancellation. We will respond to you within ten days after the receipt of the written request."

No unfair discriminatory practices were detected in the canceled policy review.

Cancelled policies that were at insured's request had proper documentation. No exceptions were noted.

Cancellation and Non-renewal Standard #2 *- Unearned premiums are correctly calculated and returned to appropriate party in a timely manner in accordance with statutes, rules and regulations.*

Calculation of unearned premium was in accordance with policy provision and state law.

Unearned premium was returned to the appropriate party in a timely manner. No exceptions were noted.

Rescissions

The Company had no rescissions during the period of the examination.

CLAIM HANDLING PRACTICES

According to the Company, 99% of all claims are reported directly to the agent. The claim is then forwarded to the Home Office. The Home Office verifies policy and coverage and sets the claim up on the claims computer system. A "notice of loss" is sent to the adjuster in the field. The adjuster maintains a claim file in the field and the Home Office also maintains a claim file. The adjuster settles the claim and forwards his file to the Home Office for filing.

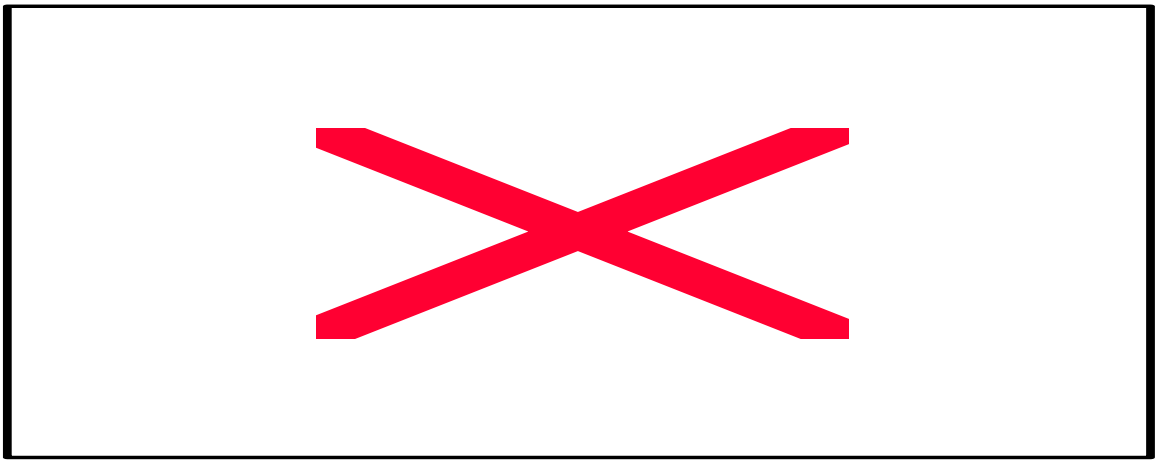
The Company does not maintain written claim handling procedures. The Company has no procedures for timely contact or settlement of claims.

The Company has written storm procedures when it is apparent a storm will create numerous claims. The Company established a "single file system procedure" beginning in 2002 that outlined several claim handling procedures.
Recommendation: The Company should adopt and implement written claim handling procedures with contact and settlement guidelines.

Paid Claims

Paid Claim Handling Standard #1 *- The initial contact by the Company with the claimant is within the required time frame.*

Claims were reported to the Company and its agents via the telephone or in person. A random sample of 100 files was selected for review. The initial contact by the company with the claimant was measured in calendar days from the date first notice of loss was received until the Company contacted the claimant. The results are noted in the schedule below.



One claimant was contacted in 20 calendar days. A contract adjuster handled this claim during a high claim volume time. All other claimants were contacted within five calendar days. Claimants were contacted in an average of 1.26 days.

Paid Claim Handling Standard #2 *- Investigations are conducted in a timely manner and reasonable standards are adhered to for the prompt investigation of claims.*

Claim files were reviewed to determine if the investigation by the Company was prompt. All investigations were begun promptly. Some claims were held open waiting estimates or receipts. During the examination period, the Company experienced a high volume of claims due to a storm. The Company stated they received in excess of 6,000 claims due to a hailstorm. The Company sent out postcards notifying the claimants of possible delays. No unreasonable exceptions were noted.

Paid Claim Handling Standard #3 *- Claims are resolved in a timely manner.*

Claim files were tested to determine payment times. Payment time on each claim was calculated, in calendar days, from the time the claim was ready for payment until the date it was paid and the results are noted in the table below. "Claim ready for payment" was defined as the date the claimant supplied pertinent information for claim settlement such as estimates, invoices, proof of ownership, etc.

Number of Days to Pay	
0-15 calendar days	85
16-30 calendar days	12
31-45 calendar days	0
46-90 calendar days	3
91-120 calendar days	0
over 120 calendar days	0
Total	100

In the 100 files reviewed 85 were paid within 15 calendar days, 12 claims were paid between 16 and 30 calendar days, and 3 were paid between 46 and 90 calendar days. All claims were paid within 90 days.

Paid Claim Handling Standard #4 *- The Company responds to claim correspondence in a timely manner.*

The Company responded to claim correspondence received in a timely manner. Most correspondence was done over the telephone or in person. No exceptions were noted.

Paid Claim Handling Standard #5 *- Claim files are adequately documented to support the decision made.*

The Company maintains a physical claim file containing such things as police reports, estimates, photos, medical bills, and correspondence. The Company also maintains electronic claim file notes on its computer system.

From the claim sample tested, three claims were not adequately documented to support the decisions made.

In two claim files documentation did not support the reason for payment delay. Documentation did not indicate when the claims were inspected.

There was no documentation in one file to support damage to a totaled vehicle. Subsequently, the Company stated the damage was assessed at a drive through location.

Recommendation: The Company should develop and implement procedures to assure that all files are adequately documented to support the decisions made.

Paid Claim Handling Standard #6 *- Claim files are properly handled in accordance with policy provisions and state statutes and/or company policy.*

The claim files reviewed were handled in accordance with policy provisions and state statutes.

Paid Claim Handling Standard #7 *- Company uses the reservation of rights and excess of loss letters when appropriate.*

The Company does not have written procedures for the use of reservation of rights or excess of loss letters.

Claim representatives are verbally instructed to issue a reservation of rights letters or a non-waiver agreement when coverage issues are questionable. The Company had no situations where a reservation of rights letter was necessary. No exceptions were noted.

Claim files were reviewed to determine if the amount of loss would exceed policy limits. There was no case where the amount of loss exceeded policy limits requiring an excess of loss letter being sent to the insured. There were no exceptions noted.

Recommendation: The Company should adopt and implement written procedures for the use of reservation of rights and excess of loss letters.

Paid Claim Handling Standard #8 *- Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.*

Paid claim files were reviewed to determine if subrogation recovery is made in a timely and accurate manner. The Company distinguishes between whether or not a claim has subrogation potential. Subrogation was recovered in two paid claims. The deductible was refunded to the insureds in 0 and 12 calendar days, respectively.

No long-term subrogation cases were identified to determine if periodic payments were made on a no less than pro rata basis.

Recommendation: The Company should adopt and implement written procedures for subrogation and recovery.

Paid Claim Handling Standard #9 *- Company claim forms are appropriate for the type of coverage.*

The Company does not require a claimant to use a specific claim form. Notice of claim is received via the mail, telephone, or through agents. Specific claim information is entered on the Company electronic claim file system on a screen titled “claim loss notice.”

The “claim loss notice” contains insured/claimant information, policy information, reserve amounts, and notes on the loss being reported. For automobile claims, the Company requires the insured/claimant to fill out a “report of accident and claim” form.

Paid Claim Handling Standard #10 *- Claim files are reserved in accordance with the Company’s established procedures.*

The Company does not have a claim procedure manual with established reserving practices. The Company established a new reserving philosophy with guidelines effective February 2002.

Individual reserves are evaluated and posted for each line of business when the claim is opened. There was no indication of reserve adjustments made in the paid claims reviewed. Reserves were reviewed to determine if they were excessive or inadequate. Reserve amounts appear to be

adequate and in line with Company practice.

Paid Claim Handling Standard #11 *- Canceled benefit checks and drafts reflect appropriate claim handling practices.*

To determine whether claim proceeds were being promptly mailed or delivered a time study was performed. The Company was requested and did provide a copy of the front and back of 10 randomly selected canceled benefit checks. Nine checks were remitted within 10 calendar days and one check was remitted within 24 calendar days. It appears the Company was delivering benefit checks timely. No exceptions were noted.

Claim files contained carbon copies of checks. Checks included correct payee and were for the correct amount. No exceptions were noted.

Checks did not indicate payment was final when such was not the case. No exceptions were noted.

Checks did not purport to release the insurer from liability when such was not the case.

Check endorsements were consistent with payee and no exceptions were noted.

The Company did not use drafts in the claim files reviewed.

Denied Claims and Closed Without Payment

Denied Claim Handling Standard #1 *- The initial contact by the company with the claimant is within the required time frame.*

The denied claim sample was reviewed to determine the number of calendar days the Company took to contact claimants once notice of loss was received. The results are noted in the table below.

Number of Days to Contact	
0-15 calendar days	23
16-30 calendar days	2
31-45 calendar days	0
46-90 calendar days	0
91-120 calendar days	0
Total	25

Denied Claim Handling Standard #2 *- Investigations are conducted in a timely manner.*

The Company does not have a claim procedure manual or written standards for the prompt investigation of claims.

The North Dakota Century Code does not specify a time frame for the prompt investigation of claims. N.D. Cent. Code § 26.1-04-03 (9)(c) states the Company should “adopt and implement reasonable standards for the prompt investigation of claims.”

Recommendation: The Company should adopt and implement written standards for the prompt investigation of claims.

Denied Claim Handling Standard #3 *- Claims are denied in a timely manner.*

The claim sample was tested to determine the number of calendar days required to deny a claim and the results are noted in the table below.

One exception was noted. A claim was held open for 175 days and file documentation did not indicate why. The examiner inquired as to the reason for delay and the adjuster indicated the claimant held the file open awaiting action.

No other exceptions were noted.

Number of Days Deny	
0-15 calendar days	21
16-30 calendar days	3
31-45 calendar days	0
46-90 claendar days	0
91-120 calendar dars	0
over 120 calendar days	1
Total	25

Denied Claim Handling Standard #4 *- The Company responds to claim correspondence in a timely manner.*

Correspondence contained in claim files was reviewed to determine if the Company response was timely. The Company responded to claim correspondence in a timely manner. No exceptions were noted.

Denied Claim Handling Standard #5 *- Claim files are adequately documented to support the decisions made.*

Claim files were reviewed to determine if file documentation was adequate to support the decision made. During the examination period, the Company maintained two files per claim. One file was maintained in the Home Office and one file was maintained in the field by the adjuster. In 2002, the Company began maintaining one claim file per claim. The examiner was supplied with the Home Office file for testing. The Home Office file was not always complete and additional information had to be requested from the field file. The Company also maintains claim file notes electronically on its computer system.

Between the two claim files and electronic claim file notes, adequate documentation was received to support the decisions made.

During the period of examination one claim file did not contain adequate documentation. One claim was held open for 175 days and file documentation did not indicate a reason for the delay.

Recommendation: Documentation should indicate why claim files are being held open.

Some explanations for denial were not specific, such as “no coverage for this peril.”

Recommendation: When a claim is denied for lack of coverage the company should quote specific policy provisions when possible.

Denied Claim Handling Standard #6 *- Denied and closed without payment claims are handled in accordance with policy provisions and state law and/or Company policy.*

Denied claim files were handled in accordance with policy provisions and state statutes. No exceptions were noted.

Closed Litigated Claims

Closed Litigated Claim Handling Standard #1 *- Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.*

A sample of five litigated claims was selected for review from a population of 18 claims that were litigated in 2001.

Litigated claim files reviewed did not indicate problematic claim handling practices on the part of the Company. Two claimants were denied because the Company believed there was negligence on the part of the insureds. The Company accepted liability in the remaining three claims but disagreed with the amount of damages sought by the claimant.

Closed Litigated Claim Handling Standard #2 *- Claim files are adequately documented to support the decision made.*

The structure of the litigated claim files was orderly and legible. File documentation including dates, notations, memoranda, etc. was sufficient to support the decisions made. No exceptions noted.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. The Board should review the Bylaw provisions relating to nominations for candidates for the Board of Directors to allow policyholders to vote for multiple candidates for an open Board seat. See *Examiners Comments concerning Board Restructuring Proposal* on pages 3 and 4.

2. The Board should propose removing or revising Article 12 of its Articles of Incorporation so that a Director with a conflict of interest regarding a matter presented to the Board must recuse himself from discussions relating to and the voting on the matter. See *Examiners Comments concerning Conflict of Interest* on page 4.

3. All Board meetings be recorded and transcribed and all unanimous decisions made by the Board be signed showing each Board member vote. See *Examiners Comments concerning recommendations to Company Operations* on page 4.

4. There should be a feasibility and actuarial study justifying the royalty payments

made by the Company to the Farm Bureau. See *Examiners Comments concerning recommendations to Company Operations* on page 4.

5. The Company should adopt written complaint handling procedures. See *Commissioner Complaint Handling Standard #1* on page 4.

6. The Company should adopt and implement written reasonable standards for the prompt handling of written communications primarily expressing a grievance from insureds and claimants, as required by N.D. Cent. Code § 26.1-04-03(10). See *Internal Complaint Handling Standard #1* on page 6.

7. The Company should adopt and implement a standard for timely response to internal complaints. See *Internal Complaint Handling Standard #3* on pages 6 and 7.

8. The Company should adopt and implement standards and procedures to resolve internal complaints on a timely basis. See *Internal Complaint Handling Standard #3* on pages 6 and 7.

9. The Company should adequately document internal complaint files. See *Internal Complaint Handling Standard #4* on page 7.

10. Applicants should be advised that credit reports are used in the determination of risk and their right to receive a copy of that report. See *Rejections and Declinations Standard #1* on pages 8 and 9.

11. The Company should adopt and implement written claim handling procedures with contact and settlement guidelines. See overall *Claim Handling Practices* on pages 10 and 11.

12. The Company should develop and implement procedures to assure that all files are adequately documented to support the decisions made. See *Paid Claim Handling Standard #5* on page 12.

13. The Company should adopt and implement written procedures for the use of reservation of rights and excess of loss letters. See *Paid Claims Handling Standard #7* on page 13.

14. The Company should adopt and implement written procedures for subrogation and recovery. See *Paid Claims Handling Standard #8* on page 13.

15. The Company should adopt and implement written procedures for the prompt investigation of denied claims. See *Denied Claims Handling Standard #2* on page 14.

16. Documentation should indicate why claim files are held open. See *Denied Claims Handling Standard #5* on page 15.

17. When a claim is denied for lack of coverage the Company should quote specific policy provisions when possible. See *Denied Claims Handling Standard # 5* on page 15.

ACKNOWLEDGEMENT

In addition to the undersigned, Terrence J. Meagher, CIE, CFE, CPA and Timothy R. Nutt, AFE, AIRC, examiners all representing the North Dakota Insurance Department, participated in this examination of Nodak Mutual Insurance Company.

Respectfully submitted,

_____

Donald R. Koelker, CIE, FLMI, AIRC, ALHC
Examiner-in-Charge
For the State of North Dakota
Department of Insurance

HUFFTHOMAS

AFFIDAVIT

STATE OF FLORIDA }
} ss
COUNTY OF VOLUSIA }

Donald R. Koelker, being duly sworn, upon his oath deposes and says:

That he is an examiner appointed by the Commissioner of Insurance for the State of North Dakota;

That a target market conduct examination was made of **Nodak Mutual Insurance Company** for the period from January 1, 2001 through December 31, 2001;

That the foregoing 18 pages constitute the report to the Commissioner if Insurance of the State of North Dakota; and

That the statements, exhibits and data therein contained are true and correct to the best of his knowledge and belief.

Donald R. Koelker, CIE, FLMI, AIRC, ALHC
Examiner-in-Charge
For the State of North Dakota
Department of Insurance

Subscribed and sworn to before me on the 22 day of May, 2003.

Notary Public for the State of
My Commission Expires:

SEABORN B. JONES, III
MY COMMISSION # CC 860539
EXPIRES: September 30, 2003
Bonded Thru Notary Public Underwriters

APPENDIX A – COMPANY LETTER OF REPRESENTATION

Nodak Mutual Insurance Company

1101 1ST Avenue North
P.O. Box 2502
Fargo, North Dakota 58108-2502
701-298-4200 • 877-814-5011
www.nodakmutual.com

March 19, 2003

Donald R. Koelker, CIE, AIRC
For: North Dakota Department of Insurance
Huff, Thomas & Company
4700 Belleview, Suite 208
Kansas City, MO 64112

Re: Letter of Representation

In connection with the target market conduct examination of Nodak Mutual Insurance Company conducted, for the purpose of determining, as of December 31, 2001: the Company's ability to fulfill and manner of fulfillment of the respective obligations; the nature of operations; whether proper treatment to has been given to the policyholders and other appropriate persons; and, whether the Company has complied with the North Dakota Century Code and North Dakota Rules and Regulations, I hereby certify, to the best of my knowledge and belief, the following representations made to you during your examination.

The transactions and business affairs of Nodak Mutual Insurance Company are conducted in compliance with the statutes, rules and regulations, and procedures of the State of North Dakota in all material respects, except in the instances specifically described as follows (insert NONE if there are no exceptions):

NONE

All corporate powers are exercised by or under the authority of the duly qualified and constituted Board of Directors of the Company and the business affairs and transactions of the Company is managed under the direction of such Board of Directors, all in accordance with the duties and responsibilities conferred upon the Board of Directors by the Articles of Incorporation, By Laws, and North Dakota Law.

Pursuant to § 27-2-23, Century Code of North Dakota, we have made available to you in their entirety:

> All books, records, accounts, papers, documents, and computer and other recordings in the Company's possession relating to its accounts, transactions and affairs, to its treatment of policyholders and other appropriate persons, compliance with the North Dakota Code and the

North Dakota Rules and Regulations, and to all matters relating to the period under examination.

There have been no:

Irregularities, other than employee turnover, involving management or employees who have significant roles in the internal control structure;

Irregularities involving other employees who have a material effect on the record keeping system; or

Communications from regulatory agencies concerning noncompliance with applicable requirements, or other deficiencies therein that could have a material effect in the treatment of policyholders or other applicable persons.

Violations or possible violations of laws or regulations whose effects should be considered for disclosure in the resultant market conduct report of examination.

There is no litigation against the Company that is considered material in relation to the statutory financial position of the Company.

The Company is not aware of any events not disclosed to the Market Conduct Examination occurring subsequent to the close of the books for the statutory financial statement of December 31, 2001, which may have a material effect on any of the above representations.

We understand that your market conduct examination was made in accordance with examination standards established by the North Dakota Department of Insurance, and procedures established by the National Association of Insurance Commissioners, and accordingly, included such tests of the accounting records and such other examination procedures as were considered necessary under the circumstances.

Nodak Mutual Insurance Company

David Johnston

By: Dave Johnston
Its: Interim CEO & Senior Vice President of Administrations

March 20, 2003
Dated